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COMPREHENSIVE CARE II, INC.

P.O. BOX 60583
WASHINGTON, D.C. 20039
(202) 291-2173
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November 12, 2007

Ms. Patricia VanBuren
Program Manager
825 North Capitol Street, NE, 2nd Floor
Washington, DC

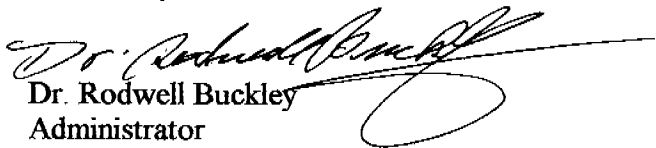
Re: 1000 Newton Street, NE Plan of Correction

Dear Ms. VanBuren:

Please find enclosed plan of corrections for the statement of deficiencies found during the visit at 1000 Newton Street NE on October 26, 2007.

Please do not hesitate to contact me at the above address if you require further information.

Yours truly,


Dr. Rodwell Buckley
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 11/01/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/26/2007
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NAME OF PROVIDER OR SUPPLIER COMP CARE II	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Governing Body failed to provide general operating direction over the facility.</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited deficient practices regarding the Governing Body's failure to provide general operating direction over the facility. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice(s) however, the deficient practice(s) remained as detailed below:</p> <p>1. The facility failed to ensure sufficient trained direct care staff were available to manage and supervise Clients #1, #2 and #3 in accordance with their needs.</p> <p>Interviews with two direct care staff and the Qualified Mental Retardation Professional and the review of personnel records and scheduling records revealed recent hiring of staff. The</p>	W 104	<p>1. Staff training inclusive of First Aid, CPR, Nutrition, BSP, Client Rights, Active Treatment, and Program Documentation will be completed by 11/20/07</p>	11-20-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

[Signature]

11/12/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1</p> <p>records reflected gaps in the staffing levels, which reportedly were being filled by staff from other agency homes, when needed. The facility lacked evidence that newly hired staff or the staff from other homes had been trained on the active treatment components and special needs of the clients. [See W189]</p> <p>The POC dated August 28, 2007 documented - Staff training inclusive of First Aid, CPR, Nutrition, BSP, Client Rights, Active Treatment, and Program Documentation on an ongoing basis and scheduled monthly by September 15, 2007.</p> <p>It should be noted that interview with a staff member on October 26, 2007 at 12:10 PM revealed the staff member was hired on October 11, 2007. The staff member revealed that he/she had not received training on the clients' active treatment components and/or special needs. Additionally, the staff member revealed that he/she had not been trained on the domains specified in the POC (First Aid, CPR, Nutrition, BSP, Client Rights, Active Treatment, and Program Documentation).</p> <p>According to interview with the Qualified Mental Retardation Professional (QMRP) on October 26, 2007 at 12:13 PM newly hired staff have not been trained in the domains mentioned on the POC. The QMRP further revealed that First Aid, CPR, BSP and Program Documentation inservices had not been conducted for any staff at the time of the monitoring visit.</p> <p>2. The facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional. [See W159]</p>	W 104			

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W 104	Continued From page 2 The POC dated August 28, 2007 documented - Program has new QMRP since July 1, 2007. Documentation is reviewed monthly and coaching of counselors is on going by August 13, 2007. According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. 3. The facility failed to ensure Pharmacy Reviews of the client's medications were conducted timely. [See W362] The POC dated August 28, 2007 documented - Pharmacist review of medication will be conducted quarterly by August 25, 2007. According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. Review of the Clients #1, #2, #3's record revealed that the last pharmacy review was conducted on April 25, 2007. It should be noted that at 2:25 PM the pharmacist came in, at the request of the nurse, to review the clients' records. 4. The facility failed to ensure four of ten staff were currently certified in emergency procedures. [See W192] The POC dated August 28, 2007 documented - Training of staff is on going and will follow a monthly schedule including CPR and First Aid by August 25, 2007. According to interview with the QMRP on October	W 104	2. Staff have received training on program goals and documentation 3. Pharmacist review of medication will be conducted quarterly. The pharmacist last came in to review the records on 10/26/07. 4. Two of the four staff have stopped working for this provider. The other two have received training in CPR and First Aid. Please find evidence herewith.	11-06-07 10-26-07 11-03-07	

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W 104	Continued From page 3 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. The QMRP further revealed that the class was to be held on November 3, 2007. At the time of the survey, the facility failed to ensure the POC had been implemented.	W 104			
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure treatment records and assessments were maintained in the facility for three of the three sampled clients. (Clients #1, #2, and #3) The findings include: On August 3, 2007 the State Agency (SA) cited deficient practices regarding the facility's failure to ensure treatment records and assessments were maintained. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: Interviews conducted with the LPN on August 2 and August 3, 2007 regarding documentation of the health care treatments and assessments for Clients #1, #2 and #3 revealed the following: Incomplete documentation was noted on the July 2007 Medication Administration Record (MAR) of Ensure Plus provided to Client #3 to prevent	W 111			

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W 111	Continued From page 4 weight loss. The POC dated August 28, 2007 documented - Ensure is given as ordered. Documentation of this order will be recorded on the MAR by August 24, 2007. According to interview with the facility's nurse on October 26, 2007 at 2:24 PM and record review, Client #3 was to receive the supplement (Ensure) three times a day. Documentation was to be completed for the supplement at 7:00 AM, 12:00 PM, and 7:00 PM. Further review of the record revealed that there was no documentation for administration of the ensure on October 1, 2, 3, 4, 5, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21-25. It should be noted that the nurse revealed the clients were on vacation on October 21-25, 2007.	W 111		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP) for three of three clients residing in the facility. (Clients #1, #2, and #3) The findings include: On August 3, 2007 the State Agency (SA) cited deficient practices regarding the facility's failure to	W 159	1. Ensure is given as ordered. The medication nurse will be charged with giving and documenting of Ensure intake.	11-01-07

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159	<p>Continued From page 5</p> <p>ensure each client's active treatment program was integrated, coordinated and monitored by the QMRP. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice(s) however, the deficient practice(s) remained as detailed below:</p> <p>1. The QMRP failed to coordinate Client #1's behavioral needs with the day program.</p> <p>On August 1, 2007 at 11:55 AM, Client #1 was observed throwing a bag of connecting blocks on the floor from a plastic bag located on the table when she was requested to complete a Lock Puzzle. Interview with the classroom instructor revealed the client was sometimes non-compliant and would throw objects on the floor.</p> <p>Record verification at the day program revealed incidents of spitting in the water fountain and other locations, throwing objects and attempted property destruction. The classroom instructor acknowledged the client did not have a formal behavior management program at the day program; however behaviors were documented on an "Interim Data Sheet" when the client exhibits them. The classroom instructor indicated that quarterly reports were sent to the group home to be monitored by the QMRP.</p> <p>Interview with the QMRP on August 1, 2007 revealed Client #1 had a behavior support plan which addressed the following targeted behaviors: (a) Misuse/inappropriate use of toilet paper/napkins; (b) Inappropriate spitting.</p> <p>Further interview with the QMRP on August 2, 2007 and the record verification revealed no behavioral data from the day program was</p>	W 159	<p>1. A case conference is scheduled with the day program to address client #1's behavior needs. The objective of the case conference will be to put in place a Behavior Support Plan at her day program. The QMRP will monthly visit client #1 at her day program to monitor behavior tracking and documentation.</p>	11-20-07

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159	<p>Continued From page 6</p> <p>available. There was no evidence the QMRP coordinated with Client #1's day program to determine if the targeted or other maladaptive behaviors were exhibited in that setting.</p> <p>The POC dated August 28, 2007 documented - QMRP will monitor day program monthly and review all documentation from day program to ensure proper treatment of person #1's targeted behavior by September 10, 2007.</p> <p>Interview with the QMRP on October 26, 2007 at 2:05 PM revealed that he/she had not visited the day program since the recertification survey on August 3, 2007. Additionally, the QMRP revealed that the documentation from/at the day program had not been reviewed.</p> <p>2. The QMRP failed to coordinate services to ensure Client #2 received a speech assessment and communication objective as ordered by the court.</p> <p>Interview with the QMRP on August 2, 2007 revealed that during Client #2's annual court hearing in March 2007 the judge ordered that the facility implement a formal communication training objective for the client. Record verification confirmed the court ordered that the interdisciplinary team (IDT) develop and implement the formal functional language program in the Behavior Support Plan (BSP) which related to identifying the items the client desires and screams about. Although the review of the current BSP dated June 5, 2007 revealed a "Response Guidelines: Screaming as a communicative tool", the review of the current IPP implemented after the August 3, 2006 Individual Support Plan (ISP) revealed no objective was</p>	W 159	<p>2. Person 2's Speech goal is currently being implemented as specified. Staff have been in-serviced on proper documentation of this program.</p>	11-06-07

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159	<p>Continued From page 7</p> <p>developed to address the screaming behavior.</p> <p>The POC dated August 28, 2007 documented - Speech program to address behavior and court order is currently being reviewed by DDS speech pathologist. Person #2 is also scheduled for assessment from providers Speech Pathologist on August 31, 2007. The completion date to address this deficient practice was September 4, 2007.</p> <p>According to the initial cited deficient practice, the QMRP failed to ensure a speech assessment and communication objective had been attained for Client #2. Interview with the QMRP on October 26, 2007 at 2:32 PM revealed a communication objective had been written but, at the time of the survey, the objective had not been implemented.</p> <p>3. The QMRP failed to ensure each employee was provided with initial and continuing training that enabled them to perform duties effectively, efficiently, and competently. [See W189]</p> <p>The POC dated August 28, 2007 documented - Trainings are scheduled monthly and ongoing monitoring of the home and coaching is provided informally at least twice weekly by August 24, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to verify the POC for the aforementioned deficient practice.</p> <p>4. The QMRP failed to coordinate services to ensure Client #3 received a comprehensive functional assessment of her fingerlicking behavior. [See W214]</p>	W 159	<p>3. Initial training for new employees will be conducted on their first day to the facility. An orientation checklist has been developed to ensure that all areas of training are covered. New staff have been trained and on programs, person rights, documentation, BSP, and Nutrition</p> <p>4. A Behavior Support Plan which spells out functional assessment and proactive means of addressing client #3 finger licking has been put in place. See herewith.</p>	<p>11-06-07</p> <p>11-11-07</p>

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159	<p>Continued From page 8</p> <p>The POC dated August 28, 2007 documented - Behavior data is kept and presented to behavior therapist and HRC committee for review and further recommendations.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the aforementioned deficient practice had been addressed. According to interview with the QMRP, Client #3 had not been assessed for her fingerlicking behavior. At the time of the survey, the facility failed to provide evidence that verified the POC and addressed the cited deficient practice.</p> <p>5. The QMRP failed to ensure the type of data collected for Client #2's individual program plan (IPP) objective on safety sign identification allowed assessment of the client's progress. [See W237]</p> <p>The POC dated August 28, 2007 documented - Goal will be modified with new ISP to allow for assessment of person #2's progress/lack of progress of this goal by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the POC had been implemented and the aforementioned deficient practice was addressed. According to interview with the QMRP and record verification, Client #2's safety sign identification program had not been modified to specify what the client was to identify.</p> <p>6. The QMRP failed to ensure the individual program plan (IPP) included training in personal skills necessary for privacy for Client #2 and on good hygiene for Client #1. [See W242]</p>	W 159	<p>5. Program has been modified to specify which signs client #2 is to identify. Please find evidence herewith. Program goal will be monitored weekly by the QMRP to ensure proper implementation.</p>	11-01-07

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159	<p>Continued From page 8</p> <p>The POC dated August 28, 2007 documented - Behavior data is kept and presented to behavior therapist and HRC committee for review and further recommendations.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the aforementioned deficient practice had been addressed. According to interview with the QMRP, Client #3 had not been assessed for her fingerlicking behavior. At the time of the survey, the facility failed to provide evidence that verified the POC and addressed the cited deficient practice.</p> <p>5. The QMRP failed to ensure the type of data collected for Client #2's individual program plan (IPP) objective on safety sign identification allowed assessment of the client's progress. [See W237]</p> <p>The POC dated August 28, 2007 documented - Goal will be modified with new ISP to allow for assessment of person #2's progress/lack of progress of this goal by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the POC had been implemented and the aforementioned deficient practice was addressed. According to interview with the QMRP and record verification, Client #2's safety sign identification program had not been modified to specify what the client was to identify.</p> <p>6. The QMRP failed to ensure the individual program plan (IPP) included training in personal skills necessary for privacy for Client #2 and on good hygiene for Client #1. [See W242]</p>	W 159	<p>5. Program has been modified to specify which signs client #2 is to identify. Please find evidence herewith. Program goal will be monitored weekly by the QMRP to ensure proper implementation.</p>	11-01-07

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159	<p>Continued From page 9</p> <p>The POC dated August 28, 2007 documented - Staff training on persons rights and privacy by August 24, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review revealed that staff were trained on client rights and privacy on August 24, 2007. However, continued interview with the QMRP on October 26, 2007 at 3:03 PM revealed that no training mechanism had been developed to assist Client #2 with attaining skills necessary for privacy and the maintenance of good hygiene.</p> <p>7. The QMRP failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), Clients #1 and #2 received a continuous active treatment plan consisting of needed interventions to achieve identified objectives. [See w249]</p> <p>The POC dated August 28, 2007 documented - Staff will be inserviced on person #1 and person #2's IPP. Monitoring and coaching of programs will be completed monthly by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 at 3:03 PM revealed that there had been not training on Client #1's behavior support plan since the August 3, 2007 survey. Additionally, the QMRP revealed that Client #2's purchasing program had not been devised and/or implemented at the time of the monitoring visit.</p> <p>8. The QMRP failed to ensure data relative to the accomplishment of Client #3's behavioral objectives was documented. [See W252]</p> <p>The POC dated August 28, 2007 documented -</p>	W 159	<p>6. A program goal has been put in place to address privacy issues related to client #2. Client #1's program will be amended to address hygiene pertaining to drooling.</p> <p>7. Staff have been trained on client #1's BSP. Client 2's purchasing program has been devised and currently being implemented. The QMRP will on a weekly basis monitor program implementation and documentation.</p> <p>8. Behavior frequencies will be collected and presented monthly at psychiatric review meetings. The psychologist has been charged with the responsibility of collecting and presenting behavior data frequencies to the psychotropic medication review team. Staff have been trained on accurate documentation of behaviors.</p>	<p>11-06-07</p> <p>11-01-07</p> <p>11-01-07</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/26/2007
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 159	Continued From page 10 QMRP monthly review will include a review of MAR documentation. The completion date to address this deficient practice was September 4, 2007.	W 159			
W 189	Interview with the QMRP and review of the psychotropic medication review for August 24, 2007 through September 24, 2007 on October 26, 2007 at 3:11 PM failed to ensure documentation on the form that identified the frequency of incidents of the targeted behaviors. At the time of the survey, the facility failed to ensure the POC had been developed and/or implemented to ensure the deficient practice was addressed. 483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that each employee received initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: On August 3, 2007 the State Agency (SA) cited deficient practices regarding the facility's failure to ensure each each employee received initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice(s) however, the deficient	W 189			

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E OF PROVIDER OR SUPPLIER

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WASHINGTON, DC 20019

192 483.430(e)(2) STAFF TRAINING PROGRAM

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W 192	<p>Continued From page 12</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each employee who works with the clients received timely training focused on skills and competencies to address the clients' emergency medical needs.</p> <p>The finding includes:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure each employee who worked with the clients received timely training focused on skills and competencies to address the clients' emergency medical needs. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>The facility failed to ensure current training in cardiopulmonary resuscitation (CPR) was maintained for each employee.</p> <p>The review of training records provided to the surveyor for review on August 2, 2007 beginning at 9:30 AM revealed that five of the ten employees working with the residents of the facility lacked current CPR certification. During interview with the Program Manager/Qualified Mental Retardation Professional, he acknowledged that the CPR training/certification for the identified staff had either expired or had not been done.</p>	W 192			

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192	Continued From page 13 The POC dated August 28, 2007 documented - CPR and First Aid Certification and recertification class scheduled for September 15, 2007. According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. The QMRP further revealed that the class was to be held on November 3, 2007. At the time of the survey, the facility failed to ensure the POC had been implemented.	W 192	Cross Reference W 104 (4)	11-06-07
214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a comprehensive functional assessment of behavioral needs was conducted for one of three clients residing in the facility. (Client #3) The findings include: On August 3, 2007 the State Agency (SA) cited a deficient practices regarding the facility's failure to ensure a comprehensive functional assessment of behavior need was conducted for Client #3. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: The facility failed to ensure an assessment of Client #3's finger licking/sucking behavior.	W 214		

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214	<p>Continued From page 14</p> <p>Interview with direct care staff on July 31, 2007 at 7:10 PM revealed the client required verbal prompting to complete the steps of hand washing. On July 31, 2007 at 7:25 PM, Client #3 was observed sitting on the couch, intermittently placing her fingers in her mouth and appeared to be playing in her saliva. The client also seemed to be listening to music on the radio beside her in the corner of the living room.</p> <p>Upon observation of the client at 7:30 PM, the Qualified Mental Retardation Professional (QMRP) looked for a washcloth to clean the client hands "because she had been licking her fingers". A direct care staff told the client "put your hand down." At 7:32 PM the client was observed continuously licking her fingers. The staff commented that she had already washed the client's face and hands twice before dinner and once after dinner. Another staff then escorted the client to the bathroom to wash her hands. From 7:41 PM to 7:52 PM Client #3 remained on the couch alone beside the radio and was again licking her fingers. Observations on August 1, 2007 at 4:00 PM also reflected continued fingerlicking behavior.</p> <p>Interview with staff on July 31, 2007 and August 1, 2007 revealed the client exhibits the fingerlicking behavior often and must have her hands washed when she was observed doing it. The review of the clinical record revealed the client was a Hepatitis B carrier.</p> <p>Record review revealed a psychological assessment and a behavior support plan (BSP) dated February 13, 2007. The fingerlicking behavior was not identified or addressed in either</p>	W 214	<p>Cross Reference W 159 (4)</p>	11-11-07

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W 214	Continued From page 15 document. The POC dated August 28, 2007 documented - Psychologist will develop and train staff on a plan to address person #3's behavior by September 18, 2007. Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the aforementioned deficient practice had been addressed. According to interview with the QMRP, Client #3 had not been assessed for her fingertlicking behavior. At the time of the survey, the facility failed to provide evidence that verified the POC and addressed the cited deficient practice.	W 214			
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan specified the type of data necessary to be able to assess progress toward the desired objective for one of two clients in the sample. (Client #2) The finding includes: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure that each written training program	W 237			

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E OF PROVIDER OR SUPPLIER

MP CARE I I

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237	<p>Continued From page 16</p> <p>designed to implement the objectives in the individual program plan specified the type of data necessary to be able to assess progress toward the desired objective. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>The facility failed to ensure the type of data collected for Client #2's individual program plan (IPP) on safety sign identification allowed assessment of the client's progress.</p> <p>On July 31, 2007 at 6:40 PM staff was observed showing Client #2 safety signs. Staff indicated the client was learning to identify different safety signs which were seen in the community. Record review revealed an objective scheduled to be implemented daily which stated that the client "will identify safety signs found in the community on 80% of trials per month for three months". The review of the instructions for implementing the objective indicated the client will point to what the picture of the sign means. Further review of the instructions revealed the data collection form stated "identifies" and did not mention what the client is to identify.</p> <p>The POC dated August 28, 2007 documented - See Response to W159 and identified the corresponding number. The response in W159 revealed that the goal would be modified with the new ISP to allow for assessment of person #2's progress/lack of progress of this goal by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the POC had been implemented and the</p>	W 237	<p>Cross Reference W 159 (5)</p>	11-01-07

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NAME OF PROVIDER OR SUPPLIER

TYPE OF CARE (I)

STREET ADDRESS, CITY, STATE, ZIP CODE

**1000 NEWTON STREET NE
WASHINGTON, DC 20019**

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237	Continued From page 17 aforementioned deficient practice was addressed. According to interview with the QMRP and record verification, Client #2's safety sign identification program had not been modified to specify what the client was to identify.	W 237		
242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the individual program plan (IPP) included training in personal skills necessary for privacy and hygiene for one of two clients in the sample. [Client #2] The findings include: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure the IPP included training in personal skills necessary for hygiene and privacy for Client #2. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: The facility failed to ensure the individual program plan (IPP) included training on personal privacy behavior for Client #2.	W 242	Cross Reference W 159 (6)	11-01-07

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MS-2567(02-99) Previous Versions Obsolete

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W 242	Continued From page 19 there would be staff training on persons rights and privacy by August 24, 2007.	W 242			
W 249	Interview with the QMRP on October 26, 2007 and record review revealed that staff were trained on client rights and privacy on August 24, 2007. However, continued interview with the QMRP on October 26, 2007 at 3:03 PM revealed that no training mechanism had been developed to assist Client #2 with attaining skills necessary for privacy and the maintenance of good hygiene. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for two of two clients in the sample. (Clients #1 and #2) The findings include: On August 3, 2007 the State Agency (SA) cited deficient practices regarding the facility's failure to ensure that each client received continuous active treatment. The provider submitted a Plan of	W 249			

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249	<p>Continued From page 20</p> <p>Correction (POC) dated August 28, 2007 to abate the deficient practice(s) however, the deficient practice(s) remained as detailed below:</p> <p>1. The facility failed to ensure interventions in Client #1's behavior support plan (Behavior Support Plan (BSP) were implemented.</p> <p>Observation of the first floor bathroom on August 1, 2007 at 6:46 AM revealed no paper towel and toilet tissue were available. On August 1, 2007 at 3:45 PM a staff informed another staff that Client #1 tears off paper towels and puts them in the toilet. At 3:50 PM the staff said the paper towels and toilet paper were being removed from the first floor bathroom because anytime Client #1 sees the paper she would attempt to put the paper in the toilet and this would clog the toilet. At 5:00 PM the commode in the first floor bathroom was observed filled to the water line with what appeared to be paper towels. Staff indicated that Client #1 probably did it because she had a history of putting excess paper in the toilet. At the time of the observation no paper towel or toilet tissue were in the bathroom.</p> <p>Interview with staff indicated Client #1 misused paper when in the bathroom and that the paper supplies in the bathroom must be closely monitored. Further interview with staff revealed the removal of the paper supplies from the bathroom had been used as a proactive strategy to prevent Client #1's misuse of toilet tissue/paper.</p> <p>The review of Client #1's Behavior Support Plan (BSP) dated November 29, 2006 revealed "The presence of a female staff member is necessitated by M's ... inability to avoid the</p>	W 249	<p>1. Cross Reference W 159 (7)</p>	11-01-07

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249	<p>Continued From page 21</p> <p>misuse of toilet paper and in view of her lack of knowledge on how to use toilet paper in a hygienic and correct manner". There was no evidence Client #1's Behavior Support Plan (BSP) was implemented as written.</p> <p>The POC dated August 28, 2007 documented - See Response to W189 and identified the corresponding number. The response in W159 revealed that staff would be inserviced on person #1 and person #2's IPP. Monitoring and coaching of programs will be completed monthly by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 at 3:03 PM revealed that there had been not training on Client #1's behavior support plan since the August 3, 2007 survey.</p> <p>2. Interview with the QMRP revealed Client #2 had an Individual Support Plan (Individual Support Plan (ISP) conference on August 4, 2006. Review of Client #2's IPP on August 3, 2007 revealed it included the following objectives:</p> <p>a. Given verbal assistance M ... will purchase a greeting card for a family member on monthly trials for three months.</p> <p>b. Given physical assistance, M will mail package (card, photo, drawing) to her brother on monthly sessions for three months.</p> <p>Interview with the QMRP revealed the client's brother was her guardian, but the facility was unsuccessful in locating him. The QMRP also acknowledged and the record review revealed no evidence that the aforementioned IPP objectives had been implemented for the client.</p>	W 249	<p>2. Cross Reference W159 (7)</p>	11-01-07

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W 249	Continued From page 22	W 249			
W 252	<p>The POC dated August 28, 2007 documented - See Response to W159 and identified the corresponding number. The response in W159 revealed that staff would be inserviced on person #1 and person #2's IPP. Monitoring and coaching of programs will be completed monthly by August 31, 2007.</p> <p>Interview with the QMRP on October 26, 2007 at 3:03 PM revealed that Client #2's purchasing program had not been devised and/or implemented at the time of the monitoring visit.</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data relative to the accomplishment of the behavioral objective for one of three clients residing in the facility was documented in measurable terms. (Client #3)</p> <p>The finding includes:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure data relative to the accomplishment of an objective was documented in measurable terms. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p>	W 252			

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W 252	<p>Continued From page 23</p> <p>Observation of the medication administration on July 31, 2007 at 7:00 PM revealed Client #3 received Lorazepam 1 mg by mouth. Interview with the medication nurse revealed the medication was prescribed for behaviors.</p> <p>Interview with the primary Licensed Practical Nurse (LPM) revealed psychotropic medication reviews (PMR) were held monthly to monitor the client's response to behavioral interventions. Interview with the LPM revealed the team consisted of the psychiatrist, the psychologist, the nurse and the Qualified Mental Retardation Professional (QMRP).</p> <p>The review of psychotropic medication reviews revealed no data was recorded for the periods of February 28, 2007 - March 26, 2007, March 27, 2007 - April 23, 2007 and May 22, 2007 - June 25, 2007. It was noted on these PMRs that no data was available for the aforementioned dates. Interview with the primary LPN on August 3, 2007 at 11:36 AM revealed that the client had some behaviors during these periods. The primary LPN indicated that the QMRP was responsible for documenting the behavioral frequencies on the the PMR forms before the meetings were held. There was no evidence this necessary information was documented as required to ensure accurate monitoring of the client's response to behavioral interventions.</p> <p>The POC dated August 28, 2007 documented - Program documentation with frequency of behavior will be presented at monthly psychotropic review meeting by August 24, 2007.</p> <p>Interview with the QMRP and review of the</p>	W 252	<p>The responsibility of collecting data frequencies for psychotropic reviews has been shifted to the Behavior Consultant/Psychologist who will ensure that accurate behavior data are presented to the psychotropic review team on a consistent basis.</p>	11-01-07

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W 252	Continued From page 24	W 252			
W 263	<p>psychotropic medication review for August 24, 2007 through September 24, 2007 on October 26, 2007 at 3:11 PM failed to ensure documentation on the form that identified the frequency of incidents of the targeted behaviors. At the time of the survey, the facility failed to ensure the POC had been developed and/or implemented to ensure the deficient practice was addressed. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) failed to ensure that restrictive programs were used only with written consents, for one client residing in the facility who received psychotropic medications. (Client #3)</p> <p>The finding includes:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure its specially-constituted committee (Human Rights Committee, HRC) obtained consent for the use of restrictive programs. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>Medication administration observation on July 31, 2007 at 7:00 PM revealed Client #3 received</p>	W 263			

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263	Continued From page 25 Lorazepam 1 mg by mouth. Interview with the medication nurse revealed the medication was prescribed twice daily for behaviors. According to the nurse, the client also had a behavior support plan (BSP) to address her targeted behaviors. According to the Human Rights Committee (HRC) minutes dated January 16, 2007, the use of the medication and the BSP was reviewed and approved. There was no evidence, however, that the committee had ensured that written consent was obtained prior to the use of the restrictive behavioral strategies. The POC dated August 28, 2007 documented - Restrictive procedures will be reviewed by the HRC and consent will be obtained from a guardian or court designee by September 27, 2007. Interview with the QMRP and record review at the time of the survey, failed to provide evidence that the POC had been implemented to ensure the deficient practice was addressed.	W 263	Restrictive procedures will be reviewed by the HRC and consent will be obtained from guardian or court designee as needed	11-01-07
331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with his assessed needs for one of three clients residing in the facility. (Clients #3) The finding includes:	W 331		

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331	<p>Continued From page 26</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure that each client received nursing services in accordance with his assessed needs. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>The facility nursing services failed to ensure treatment records documenting Client #3's receipt of prescribed nutritional supplement were maintained.</p> <p>Interview with direct care staff on July 31, 2007 at 7:45 PM revealed that Client #3 received a nutritional supplement of Ensure Plus three times a day to maintain her weight. According to the staff, the client took the last available Ensure Plus to his day program; and therefore, the client did not have the Ensure supplement for the evening of July 31, 2007. Staff indicated that more would be purchased on the next day.</p> <p>Interview with the primary LPN on August 3, 2007 indicated direct care staff was responsible for documenting the administration of the Ensure Plus in the treatment book. Record review revealed that the nurse failed to consistently document the administration of Ensure Plus.</p> <p>The POC dated August 28, 2007 documented - The nurse will monitor and document the administration of Ensure by residential counselors by August 24, 2007.</p> <p>According to interview with the facility's nurse on October 26, 2007 at 2:24 PM and record review, Client #3 was to receive the supplement (Ensure)</p>	W 331	Cross Reference W 111	11-01-07

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W 331	Continued From page 27 three times a day. Documentation was to be completed for the supplement at 7:00 AM, 12:00 PM, and 7:00 PM. Further review of the record revealed that there was no documentation for administration of the ensure on October 1, 2, 3, 4, 5, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21-25. It should be noted that the nurse revealed the clients were on vacation on October 21-25, 2007. At the time of the survey, the facility failed to ensure the deficient practice had been addressed.	W 331			
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure that the pharmacist reviewed drug regimens for three of three clients residing in the facility on a quarterly basis. (Clients #1, #2 and #3) The findings include: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure a pharmacist reviewed drug regimens quarterly. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: Observation of the medication administration on July 31, 2007 beginning at 6:52 PM revealed Clients #1, #2, and #3 were each administered medications. Interview with the LPN	W 362			

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362	Continued From page 28 administering the medication and the review of the medication administration record revealed these medications were prescribed by the primary care physician. Interview with nurse and the review of the agency's policy revealed the Pharmacy review should be conducted at least quarterly. Review of the documentation on Pharmacy Review forms in the clients' medical records on August 2, 2007 beginning a 3:47 PM, revealed reviews were completed on December 20, 2006 and April 25, 2007. The POC dated August 28, 2007 documented - See Response to W104 and identified the corresponding number. The response in W104 revealed that a pharmacist would review the medication quarterly by August 25, 2007. According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. Review of the Clients #1, #2, #3's record revealed that the last pharmacy review was conducted on April 25, 2007. It should be noted that at 2:25 PM the pharmacist came in, at the request of the nurse, to review the clients' records.	W 362	Cross Reference 104 (3)	10-26-07
474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture for one of the	W 474		

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474	<p>Continued From page 29</p> <p>three clients residing in the facility. (Client #2)</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure a pharmacist reviewed drug regimens quarterly. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>1. On July 31, 2007, at 7:40 PM, Client #2 was observed asking the staff for cookies. She was instead given a snack of apple wedges. Further observation of the client revealed no visible teeth. Interview with staff revealed the client had no teeth or dentures. The client ate the apple slowly and appeared to be gumming it.</p> <p>Record review on August 1, 2007 revealed a dental consultation report dated October 19, 2006 which stated the client was edentulous and did not have dentures. According to the current physician's orders, the client was prescribed a chopped textured diet.</p> <p>2. At 4:10 PM on August 1, 2007, a staff was observed returning from the store with Clients #1 and #2 with a large can of beverage. Client #3 was given approximately 3 ounces of the beverage that contained no food thickener. The review of the client's prescribed diet revealed all of her liquids should be thickened to a honey consistency.</p> <p>The POC dated August 28, 2007 documented - Inservice of persons dietary order will be presented by the QMRP.</p>	W 474	1. Cross Reference W104 (1)	11-20-07

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NAME OF PROVIDER OR SUPPLIER

WMP CARE II

STREET ADDRESS, CITY, STATE, ZIP CODE

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WASHINGTON, DC 20019**

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474	Continued From page 30	W 474		
485	<p>According to interview with the QMRP on October 26, 2007, there had been no dietary training by the nutritionist since the recertification survey on August 3, 2007. The QMRP revealed that training was scheduled for September 26, 2007 and October 25, 2007 but were both cancelled. At the time of the survey, the facility failed to ensure the POC had been implemented to make certain the deficient practice was addressed.</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must supervise and staff dining rooms adequately.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate staff supervision in the dining room at mealtime for three of three clients residing in the facility. (Clients #1, #2, and #3)</p> <p>The finding includes:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure adequate staff supervision in the dining room at mealtime. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>The breakfast meal observation was conducted on August 1, 2007 beginning at 7:28 AM. Interview with an overnight staff indicated they were running late with breakfast. After all food was placed on the table, one of the two staff on duty was observed to return to the kitchen to</p>	W 485	<p>Each person BSP was reviewed with staff by the Behavior Consultant. Staff will be in-serviced on proper supervision of clients during meals.</p>	11-20-07

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W 485	<p>Continued From page 31</p> <p>clean up. The other staff remained in the dining room to supervise the three clients. The following observations were made:</p> <p>a. At 7:41 AM Client #2 got up from her seat at the dining table and grabbed the can of Thicket, which was placed on the table for Client #3's use. Client #2 immediately took a scoop of Thicket and poured it into her coffee and stirred it. Staff instructed the client to give the can of Thicket to her. The client immediately drank the coffee to which she had added the Thicket.</p> <p>b. At 7:33 AM Client #1 was observed spooning raisin bran and milk from the bowl onto her plate. At 7:48 AM she was observed spitting food back onto her plate. No staff intervention was observed.</p> <p>c. At 7:50 AM Client #3 was observed eating independently from a high sided plate. She was observed to overfill the spoon while scooping her food from the plate and to attempt to eat rapidly. Staff supervising the client intermittently provided verbal prompts to the client to put her spoon down.</p> <p>On August 2, 2007, the review of the client's behavior support plan (BSP) dated February 13, 2007 revealed she had an individual program plan (IPP) objective to improve her socially appropriate behavior. The objective stated the client "will eat her meals at a steady and measured pace under staff supervision". She should be instructed to put her spoon down between mouthfuls to encourage thorough chewing and to prevent her from eating at a rapid pace.</p>	W 485			

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W 485	<p>Continued From page 32</p> <p>The POC dated August 28, 2007 documented - Staff will be inserviced on active involvement and monitoring during mealtime. Staff will be in-serviced on the BSP for Person #1. Staff will receive inservice on the BSP for Person #3. The POC further documented that the corrective actions will occur by August 29, 2007.</p> <p>Interview with the QMRP and record review at the time of the survey, failed to provide evidence that the POC had been implemented to ensure the deficient practice was addressed.</p>	W 485			

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I 000	INITIAL COMMENTS A monitoring survey was conducted on October 26, 2007 to determine the facility's continued compliance with the deficiencies cited during the re-licensure survey on August 3, 2007. The findings of the survey were based on interviews and record review.	I 000			
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The finding includes: The facility failed to maintained the environment as evidenced by the concerns identified in this section of the report. The findings include: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the facility's failure to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:	I 090			

Health Regulation Administration


 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8800

89X011

If continuation sheet 1 of 15

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090	<p>Continued From page 1</p> <p>The surveyor conducted environmental observations on August 3, 2007 beginning at 3:10 PM. She was accompanied through the GHMRP by the Qualified Mental Retardation Professional (QMRP).</p> <p>1. Client #2's closet door was not secured in the tract.</p> <p>The POC dated August 28, 2007 documented - Door maintenance has been ordered and an expected remedy of this problem is on August 30, 2007.</p> <p>2. Soap scum was on bottom of the the shower curtain in the bathroom located on the second floor.</p> <p>The POC dated August 28, 2007 documented - Shower curtains are washed or replaced weekly.</p> <p>3. Window panes contained soil on the interior throughout the facility.</p> <p>The POC dated August 28, 2007 documented - Windows cleaned August 5, 2007. Maintenance of cleaning will occur bi-weekly.</p> <p>4. Client #2's clothes hamper was heavily stained/soiled.</p> <p>The POC dated August 28, 2007 documented - Clothes hampers replaced August 25, 2007.</p> <p>5. A large black piece was detached from the back of the refrigerator in the kitchen. The piece appeared to be made of rubber.</p> <p>The POC dated August 28, 2007 documented - Cover on the rear of the refrigerator was replaced</p>	1090	<p>1. Client #2's door has been repaired</p> <p>2. Shower curtains were replaced</p> <p>3. Windows have been cleaned</p> <p>4. Hamper has been replaced</p> <p>5. Hanging piece was removed</p>	<p>11-09-07</p> <p>11-04-07</p> <p>10-26-07</p> <p>10-27-07</p> <p>11-06-07</p>

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I 206	<p>Continued From page 3</p> <p>the current health certificates were Staff #2, #5, #9, and #10.</p> <p>2. Review of the consultant files on the same date revealed no current health certificates were available for consultants #2, #4, #10, and #12. It was noted that Consultants #2 and #4 had PPDs and no evidence of a health screening.</p> <p>The Program Director/ Qualified Mental Retardation Professional (QMRP) acknowledged on August 3, 2007 during interview that the aforementioned health certificates were not available during the survey.</p> <p>Interview with the QMRP and record review on October 26, 2007, failed to provide evidence of a current health certificate for staff S2 and consultant C10. At the time of the monitoring visit, the aforementioned concern regarding the failure of the GHMRP to obtain current health certificates remained.</p>	I 206	<p>2. Consultant health screenings are current</p>	11-09-07	
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure continuous training programs was provided for all personnel.</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice(s) regarding the GHMRP's failure to ensure continuous training was provide for all personnel. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to</p>	I 222			

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I 222	<p>Continued From page 4</p> <p>abate the deficient practice(s) however, the deficient practice(s) remained as detailed below:</p> <p>1. The GHMRP failed to ensure effective training to staff on the meal time supervision needs of Residents #1, #2, and #3. [See Federal Report - Citation W485]</p> <p>The POC dated August 28, 2007 documented - Staff training on programming and active treatment to be held on August 30, 2007.</p> <p>Interview with the QMRP and record review on October 26, 2007, failed to provide evidence that staff had been trained on the mealtime supervision needs of Residents #1, #2, and #3.</p> <p>2. The GHMRP failed to ensure effective training to staff on the implementation of Resident #1's and #2's behavior support plan. [See Federal Report - Citation W249]</p> <p>The POC dated August 28, 2007 documented - Staff training on person #1 and person #2's BSP will occur on August 29, 2007.</p> <p>Interview with the QMRP and record review on October 26, 2007, failed to provide evidence that the POC had been implemented to ensure the deficient practice was addressed. At the time of the monitoring visit, the GHMRP failed to provide evidence that training on the residents' BSP occurred.</p> <p>3. The GHMRP failed to ensure effective training to direct staff on documentation of data relative to accomplishment of Resident #3's behavioral objectives [See Federal Report - W252].</p> <p>The POC dated August 28, 2007 documented -</p>	I 222	<p>1. See response to W 104</p> <p>2. See response to W 104</p> <p>3. See response to W 104</p>		

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I 222	Continued From page 5 Staff training on program documentation will be held on August 29, 2007. Interview with the QMRP and record review on October 26, 2007, failed to provide evidence that the POC had been implemented to ensure the deficient practice was addressed.	I 222			
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that current training on cardiopulmonary resuscitation (CPR) was maintained for each employee. The finding includes: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure current training on cardiopulmonary resuscitation (CPR) for each employee. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: The review of training record provided to the surveyor for review on August 2 and August 3, 2007 revealed that four of the ten employees working with the residents lacked a current CPR certification. The identified staff were Staff #'s 1, 4, 6, 7 and 9. During interview with the Program Manager/Qualified Mental Retardation Professional, he acknowledged that the CPR certification for the identified staff had either expired or not been completed.	I 226			

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I 226	Continued From page 6 The POC dated August 28, 2007 documented - CPR and First Aid Training is scheduled for September 15, 2007. Staff #1, 4, 6, 7, and 9 are signed up for the class. According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. The QMRP further revealed that the class was to be held on November 3, 2007. At the time of the survey however, the GHMRP failed to ensure the aforementioned training had been conducted.	I 226	See response to W 192	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each training program included specialty areas needed by the residents being served. The finding includes: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure training in specialty areas needed by the residents being served. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice	I 229		

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I 229	<p>Continued From page 7</p> <p>however, the deficient practice remained as detailed below:</p> <p>The in-service training records on August 2 and August 3, 2007 failed to evidence that on going training was provided to direct care staff in the following areas:</p> <ul style="list-style-type: none"> (a) behavior management; (b) nutrition; (c) total communication; (d) assistive devices. <p>During interview with the QMRP on August 3, 2007, he acknowledged that some training was provided to staff on July 9, 2007, however some of the required subjects had not been covered.</p> <p>The POC dated August 28, 2007 documented - Staff training is ongoing on all domains. The consultant training is scheduled for September 18, 2007. The scheduled training for this inservice is nutrition, speech, and BSP.</p> <p>According to interview with the QMRP on October 26, 2007, there had been no dietary training by the nutritionist since the recertification survey on August 3, 2007 (see Federal Deficiency Report Citation W474). The QMRP revealed that training was scheduled for September 26, 2007 and October 25, 2007 but were both cancelled. Additional interview with the QMRP on October 26, 2007 at 3:03 PM revealed that there had been not training on Client #1's behavior support plan since the August 3, 2007 survey (See Federal Deficiency Report Citation W249). At the time of the survey, the facility failed to ensure the POC had been implemented to make certain the deficient practice was addressed.</p>	I 229	See response to W 104		

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I 291	Continued From page 8	I 291	See response to W 111		
I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the record of each resident was kept current dated and signed by all persons making an entry.</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure each resident's record was kept current, dated and signed by all persons making an entry. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>The facility failed to ensure treatment records and assessments were maintained accessible for Residents #1 and #3. [See Federal deficiency Report - Citation W111]</p> <p>The POC dated August 28, 2007 documented - Documentation of person receiving ensure will be monitored by the nurse and documented on an MAR sheet.</p> <p>According to interview with the GHMRP's nurse on October 26, 2007 at 2:24 PM and record review, Resident #3 was to receive the supplement (Ensure) three times a day. Documentation was to be completed for the supplement at 7:00 AM, 12:00 PM, and 7:00 PM. Further review of the record revealed that there was no documentation for administration of the</p>	I 291			

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I 291	Continued From page 9 ensure on October 1, 2, 3, 4, 5, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21-25. It should be noted that the nurse revealed the residents were on vacation on October 21-25, 2007. (See Federal Deficiency Report Citation W111)	I 291		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided to three of three residents in the survey. (Residents #1, #2, and #3) The findings include: On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure professional services were provided to the residents. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below: 1. The GHMRP failed to ensure the active treatment programs for Residents #1, #2, and #3 were integrated, coordinated and monitored by the qualified mental retardation professional (QMRP). [See Federal Deficiency Report - Citation W159]	I 401	1. See response to W 104	

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I 401	<p>Continued From page 10</p> <p>The POC dated August 28, 2007 documented - Person 1, 2, and 3's program are/will be monitored and reviewed monthly by QMRP. Documentation, active treatment, coaching, nutrition, psychology or any other in-service will be completed per need following monitoring. The plan was documented to be completed by September 15, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to verify the POC for the aforementioned deficient practice. (See Federal Deficiency Report Citation W159)</p> <p>2. The GHMRP failed to ensure that comprehensive functional assessments was conducted for Resident #3's fingerlicking behavior and of Resident #1's sexuality. [See Federal Deficiency Report - Citation W214]</p> <p>The POC dated August 28, 2007 documented - Universal precaution inservice and OSHA overview was completed on August 24, 2007 and will continue to be presented monthly in orientation and training review. Person #3's assessment is completed and is attached to this POC. The plan was documented to be completed by September 15, 2007.</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to provide evidence that the aforementioned deficient practice had been addressed. According to interview with the QMRP, Resident #3 had not been assessed for her fingerlicking behavior. At the time of the survey, the facility failed to provide evidence that verified the POC and addressed the cited deficient practice. (See Federal Deficiency Report Citation W214)</p>	I 401	2. See response to W 214		

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I 401	<p>Continued From page 11</p> <p>3. The GHMRP failed to ensure pharmacy reviews were conducted timely for Residents #1, #2, and #3. [See Federal Deficiency Report - Citation W362]</p> <p>The POC dated August 28, 2007 documented - Pharmacy review will occur every 90 days per policy. The plan was documented to be completed by September 15, 2007.</p> <p>According to interview with the QMRP on October 26, 2007 at 12:13 PM the POC for the aforementioned deficient practice had not been implemented. Review of the Clients #1, #2, #3's record revealed that the last pharmacy review was conducted on April 25, 2007. It should be noted that at 2:25 PM the pharmacist came in, at the request of the nurse, to review the clients' records. (See Federal Deficiency Report Citation W362)</p> <p>4. The GHMRP failed to ensure health services were provided in accordance with the needs of Residents #1, #2 and #3. [See Federal Deficiency Report - Citations W322 and W331]</p> <p>The POC dated August 28, 2007 documented - Nurse will monitor and record appointments for this treatment with family to ensure appointment is kept on a timely manner and offer transportation assistance as needed. The nurse will monitor and document the administration of Ensure by residential counselors.</p> <p>According to interview with the facility's nurse on October 26, 2007 at 2:24 PM and record review, Client #3 was to receive the supplement (Ensure) three times a day. Documentation was to be completed for the supplement at 7:00 AM, 12:00 PM, and 7:00 PM. Further review of the record</p>	I 401	<p>3. See response to W 362</p> <p>4. See response to W 331</p>	

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I 401	<p>Continued From page 12</p> <p>revealed that there was no documentation for administration of the ensure on October 1, 2, 3, 4, 5, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21-25. It should be noted that the nurse revealed the clients were on vacation on October 21-25, 2007. At the time of the survey, the facility failed to ensure the deficient practice had been addressed. (See Federal Deficiency Report Citation W331)</p> <p>5. The GHMRP failed to ensure oversight regarding food textures and food preparation. [See Federal Deficiency Report - Citations W474 and W478]</p> <p>The POC dated August 28, 2007 documented - Nutrition recommendation has been reviewed with staff. Follow up training with nutritionist to occur on September 18, 2007.</p> <p>According to interview with the QMRP on October 26, 2007, there had been no dietary training by the nutritionist since the recertification survey on August 3, 2007. The QMRP revealed that training was scheduled for September 26, 2007 and October 25, 2007 but were both cancelled. At the time of the survey, the facility failed to ensure the POC had been implemented to make certain the deficient practice was addressed. (See Federal Deficiency Report Citation W474)</p>	I 401	5. See response to W 104		
I 420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p>	I 420			

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I 420	<p>Continued From page 13</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure habilitation and training for three of three residents residing in the facility. (Residents #1, #2, and #3)</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure habilitation and training to residents in the GHMRP. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>[See Federal Deficiency Report - Citations W159, W237, W242, W249 and W252]</p> <p>The POC dated August 28, 2007 documented - See Response to W159 and W252)</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to verify the POC for the aforementioned deficient practices had been implemented and addressed the cited deficiencies. (See Federal Deficiency Report Citation W159, W237, W242, W249, and W252)</p>	I 420	<p>See responses to W 159, W 237, W 242, W 249, and W252</p>		
I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record</p>	I 500	<p>See responses to W 159, W242, W 249, & W 263</p>		

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I 500	<p>Continued From page 14</p> <p>review, the GHMRP failed to ensure the protections of each resident's rights.</p> <p>The findings include:</p> <p>On August 3, 2007 the State Agency (SA) cited a deficient practice regarding the GHMRP's failure to ensure the protection of each resident's rights. The provider submitted a Plan of Correction (POC) dated August 28, 2007 to abate the deficient practice however, the deficient practice remained as detailed below:</p> <p>[See Federal Deficiency Report - Citations W159, W242, W249, and W263.]</p> <p>The POC dated August 28, 2007 documented - See Response to W159)</p> <p>Interview with the QMRP on October 26, 2007 and record review failed to verify the POC for the aforementioned deficient practices had been implemented and addressed the cited deficiencies. (See Federal Deficiency Report Citation W159, W242, W249, and W263)</p>	I 500			

ZELMAN, YOUNT AND ASSOCIATES, LLC
Behavior Support Plan – Procedures
Prepared for: Comprehensive Care II, Inc.

Name: Shirley Parker

Address: 1000 Newton St. N.E.

Date of Birth: 11-2-1949

Date of Previous Plans: July 2005; 01-10-06; 03-15-06; 02-13-07

Revised: 11-11-07

Goal: Ms. Parker will improve her socially appropriate behavior.

Objective 1: Ms. Parker will eat her meals at a steady and measured pace under staff supervision.

Objective 2: Ms. Parker will decrease incidents of surface licking (surfaces such as the walls, blinds, curtains, blouse collars and chairs) to 1 incident per month for 3 consecutive months.

Objective 3: Ms. Parker will decrease incidents of finger licking to 1 incident per month for 3 consecutive months.

Axial Diagnoses:

Axis I: 299.00 Autistic Disorder; 312.34 Intermittent Explosive Disorder (IED) by history
 Axis II: 318.20 Profound MR, cognitive and adaptive
 Axis III: Hepatitis B Carrier; Internal Tibial Torsion; Cortical cataracts
 Axis IV: None
 Axis V: 40

Psychotropic Medications:

Ms. Parker is currently prescribed the following psychotropic medications: Neurontin 100 mg bid for impulse control; Lorazepam 1 mg /bid; Depakote 250 mg/ 500mg / am and pm. Her dosage of Risperdal was reduced from 1.5 mg / bid to 1 mg / bid on 02/28/06 by Dr. Ganz, as it was felt that she had not shown any aggressive symptoms for several months. It was further reduced to 1 mg/pm on 02/25/06, then to 0.5 mg/pm on 08/11/06, and discontinued on 10/23/06. There have been no reported changes in behavior since. Psychology will continue to monitor her behavior and participate in the psychotropic review process to provide ongoing assessment of her response to medication.

Her psychotropic medication regimen is reviewed with the Comprehensive Care psychiatrist and team every month.

Medication Reduction Plan:

At any time that Ms. Parker achieves mastery of two or more of the objectives above, the psychotropic medication review team will consider reduction in her psychotropic medication.

Relevant Background Information:

Ms. Parker was placed in Forest Haven in 1953, after a diagnosis of mental retardation. She moved to her current home in 1987. She currently shares this home with two other female residents.

Ms. Parker's level of adaptive functioning is in the profound range of mental retardation. She responds well to verbal praise, as well as to physical praise, such as pats on the back. She is able to assist during some routines of her personal care, such as putting on 'pull-up' type garments, bathing with assistance, and feeding herself with a spoon. Staff reports indicate that she displays a fear of high places, such as at the top of a tall staircase. She appears to enjoy going on community outings.

Ms. Parker's cognitive functioning is in the profound range of mental retardation. She is non-verbal but expresses her needs through vocalizations, body language and facial cues. Ms. Parker is ambulatory and is able to walk up and down stairs. Her vision appears to be within normal limits and her gross and fine motor skills are functional.

Behaviors of Concern and Functional Analysis:

Ms. Parker has had a history of behavior concerns, and in the past these included: food stealing; eating too fast; licking the floor; sitting on the floor (to resist activity); and aggression. Currently, the aggressive tendencies are no longer evident and this improvement led to the reduction and discontinuation of Risperdal on 10/23/06. Consequently, Dr. Ganz (consulting psychiatrist for Comprehensive Care II) revised her Axis I diagnosis to 'history of IED'.

Food stealing ceased to be reported as a behavioral concern over 2 years ago. Both aggression and food stealing are no longer objectives in her behavior support. Comments from staff indicate that Ms. Parker is sensitive to the tone in which she is spoken to. She has been known to respond aggressively when staff have spoken too loudly to her, or in a manner that she may interpret as threatening.

Verbal reports from direct care staff have mainly emphasized that fast eating and floor licking are her ongoing concerns. Poor documentation of behaviors by staff has been an ongoing problem at this facility and the need for daily monitoring of behavior data (by senior staff) has repeatedly been reiterated by psychology at the monthly psychotropic meetings. Inadequate staffing and changes in supervisory staff members have contributed to the laxity on this important routine.

The frequencies obtained on her previously monitored behavior of floor licking are shown below.

Target behavior	4/1/07 to 9/24/07	Monthly average
Floor Licking	173	28.8 incidents

Ms. Parker's tendency for fast paced eating is a concern that continues to need alert monitoring from staff. This behavior may be described as filling up/stuffing her mouth with food and swallowing without taking the time to chew. Such speed has been observed at mealtimes as well as at snack times. Functional analysis of this behavior suggests this is a habit developed after years of institutional living at Forest Haven. It may be reflective of her past fear of not getting enough food (or another meal) to satisfy her hunger. While in comparison to previous descriptions of this tendency, her current eating pace is reported by staff as greatly improved, staff comments also clarify that if left unmonitored with food, Ms. Parker will revert to stuffing her mouth and gulping. In view of this behavior's potential for choking, vigilant staff presence and ongoing verbal cues from staff is a must during meal/snack times. Due to her internal tibial torsion and general stiffness, her hand to mouth coordination while eating is awkward. However, Ms. Parker is able to feed herself without inordinate spillage.

In the past her behaviors included floor-sitting incidents, which were described as dropping to the floor and squatting there. This behavior was most likely a form of resistance to requests given by staff members. She does not display this behavior anymore. This objective was discontinued in her 2/13/07 BSP.

The term **surface licking** is being used here to refer to Ms. Parker tendency of licking linoleum floors, walls, blinds, curtains, blouse collars, and chairs. Initially staff at the facility had reported this behavior as targeted at the linoleum floors only. Past documentation and interviews with direct care staff did not reveal that she targeted additional surfaces. Hence, floor licking constituted one of the objectives in her previous BSP. From July 2007 however, staff members started reporting other details about Ms. Shirley's licking. For example, staff began mentioning that the licking 'had always included other surfaces' such as the walls, blinds, curtains, and chairs. More recent interviews revealed that she licked the collar of her blouse, if she got a chance to do so. With regard to the floor licking, when staff were asked to explain how Ms. Parker could lick the floor without sitting on it, staff explained that she did so by simply bending down. This happened most frequently on linoleum floors and did not extend to carpeted floors. The functional purpose behind surface licking is unclear. It is likely that surface licking denotes a compulsive urge that serves both an exploratory and stimulatory function. Ms. Parker continues

to lick these surfaces if left unmonitored. However, she has fewer incidents of floor licking if she is being watchfully supervised and when staff ensure:

- That she participates in activities according to her schedule;
- That she is encouraged to interact and communicate using her verbal and non-verbal skills with the involvement and accompanying verbalizations from staff.

Finger licking was not reported as a behavior of concern for Ms. Parker to this writer. Recent observations by survey team members, revealed that finger licking does occur and even goes unmonitored by staff members, who may be responding to this tendency with less attention than it warrants. When unmonitored, this behavior constitutes an unhygienic tendency that can lead to ingestion of harmful bacteria from the environment that Ms. Parker may acquire while touching objects/surfaces, prior to the licking. During the finger licking behavior, saliva may transfer to her fingers with which she may continue to play. As this behavior has never been reported as a concern or documented, a functional analysis is not possible at this time. It is however, surmised that lack of monitoring could lead to this behavior, as it appears to serve a self stimulatory function.

Proactive Procedures

1. Engage Ms. Parker in activities as much as possible. There should be times when she relaxes with no structured activity. If she wishes to engage in activities away from the other residents, this is permissible.
2. Praise Ms. Parker verbally and give attention whenever she participates in activities and whenever she responds to staff directives aimed at maintaining hygiene. Praise should be provided frequently during tasks/activities. Tell her specifically what she has done, that staff appreciate. For example, staff may say, "Shirley, I really like the way you helped with .../ or I really like how well you washed your hands. Thank you. That was great! / Or Shirley, you are such a great help with the (whatever the task). Great job!"
3. Use an enthusiastic and warm tone.
4. Watchfully monitor Ms. Parker's movements and whereabouts during waking hours and ensure that her hands are kept clean at all times.

Objective 1:

Procedures for Addressing Rapid Eating

1. Be present next to Ms. Parker throughout the meal to facilitate monitoring of her eating pace and to provide redirection when she paces her intake too fast.

Parker, Shirley

Behavior Support Plan / November 2007

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2. Serve small amounts of food on Ms. Parker's plate at any one time; additional food may be added as she finishes the initial portions.
3. Provide Ms. Parker with a smaller sized spoon (not a tablespoon) to eat with.
4. Instruct her to take 'one bite' of her food or 'one spoonful' and then direct her to put down the spoon as she chews and swallows. Watch to ensure she chews and swallows; when she does so, say something in the form of praise such as: 'Good job!'
5. If Ms. Parker begins to eat too fast or she is not chewing and swallowing between spoonfuls of food, staff should direct her to 'Slow down, Shirley'. Use gentle hand-over-hand assistance as needed, to ensure that she puts down her spoon between mouthfuls. Encourage mouthfuls of her drink or beverage between bites of food.

Objective 2:

Procedures for Addressing Surface Licking

1. If Ms. Parker begins licking any surface (such as the floor, walls, blinds, curtains, chairs, blouse collar), call her by name, establish eye contact if possible, and in a firm tone of voice say 'Stop Shirley!' Similarly if she is bending to lick the floor, immediately direct her to stand up; if she is leaning against the walls to lick the blinds or against the chair, call her by name, make eye contact (if possible), and call her away to a different location away from the targeted surface.
2. Immediately follow up by presenting her with an alternative activity, such as an easy house chore that staff can do alongside Ms. Parker in order to sustain her engagement period as long as possible. If engaging her in an activity is difficult to achieve, ask her to accompany you for a short walk from that targeted area/ location to another area of the house or yard (as appropriate for the time).
3. If Ms. Parker does not comply and stays bent on the floor to continue her licking (or near the wall), provide gentle touch prompts and as necessary, physically assist her (to her feet) as you guide her away from the area. This should be done with **firmness** and with gentle persuasion. Guide her to an area where she is less likely to lick, such as into the dining table or the living room away from the walls, in an area where the floor is carpeted. Redirect her to sit in a chair. Continue to monitor her. Keep her as engaged in activities as her tolerance permits.

Objective 3:**Procedures for Addressing Finger Licking:**

1. Ensure that Ms. Parker's hands are kept clean and hygienic at all times.
2. Monitor Ms. Parker's whereabouts during waking hours. If she is observed to be moving her hands/fingers close to her mouth, staff should immediately move closer and place a manipulative toy in her hands (a stress ball, sensory objects, or toys). Squeeze the stress ball using hand over hand assistance or activate her manipulation of the toy and to ensure her hands are occupied in an activity away from her mouth.
3. If she discards the manipulative toy or object just handed to her and proceeds to lick her fingers, use a firm tone of voice to say 'Stop Shirley! Come let's wipe your hands with tissue'. Repeat directive again if necessary.
4. Follow this up consistently by immediately ensuring that she wipes her hands. Gently lead her to the tissue box. As far as possible, Ms. Parker's efforts to respond to the directive should be encouraged. If however she does not respond to the directive to obtain tissue, staff should hand the tissue box to use a tissue to wipe her hands.
5. If prior to the finger licking, Ms. Parker has been floor or surface licking, staff should walk her to the bathroom and supervise that she washes her hands thoroughly.
6. Since her finger licking may be a habit that developed through several unmonitored, past episodes of licking, this is a tendency that will have to be discouraged henceforth through diligent monitoring and consistent application of the above follow up strategies, every time it happens.

Documentation:

1. During every shift, staff should document all incidents of target behaviors on the data sheets attached with this BSP. **Documentation should occur during every shift and on every day.**
2. When recording data observe the following points:
 - a. Document any possible antecedents (whatever staff might think is remotely connected to the behavior occurring); document the behavior that occurred and record in detail, all staff interventions (both what was more and less successful).

Lizzie P. Timothy
Lizzie P. Timothy
Behavior Specialist

Rebecca J. Yount
Rebecca J. Yount, Psy.D., Supervisor
Licensed Psychologist, DC # 1643

Shirley Parker:

Data Collection Sheet for Objective 1: incidents of eating food too fast during meal and snack-time.

[illegible]

Key:

11-11-07

Antecedent: Include what the consumer was doing just before the incident, what staff was doing and any related events/s.

Behavior: Describe exactly what was said (and any accompanying expressions, gestures or body language exhibited during these statements.

Consequences: Anything and everything that followed the incident; what was said and done by staff in response to the situation; whether the behavior was resolved and if so how long it took.

Shirley Parker: *DELIVERY, TOWN AND ASSOCIATES, LLC*
Data Collection Sheet for Objective 2: incidents of surface licking (linoleum/tiled floors, curtains, blinds, walls, chairs, collars)

[illegible]

11-11-07

Behavior: Describe exactly what was said (and any accompanying expressions, gestures or body language exhibited during these statements.

Consequences: Anything and everything that followed the incident; what was said and done by staff in response to the situation; whether the behavior was resolved and if so how long it took.

Data Collection Sheet for Objective 3: incidents of finger licking (including playing with saliva)

[illegible]

11-11-07

Behavior: Describe exactly what was said (and any accompanying expressions, gestures or body language exhibited during these statements).

Consequences: Anything and everything that followed the incident; what was said and done by staff in response to the situation; whether the behavior was resolved and if so how long it took.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

HEALTH CERTIFICATE FOR STAFF

Name: Sheila L. Kelly

Sex: ☐ Male ☒ Female

Date of Birth: 3-14-54

Telephone No.: _____

Address: 15705 Henrietta Dr. Accokeek

I have examined the above-named person and certify that he/she is:

- ☒ Free from disease in communicable form.
- ☒ As of this date, the person appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to other people.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ Tine ☒ PPD

Date: 9-7-07 Result: NEGATIVE

Chest X-Ray: Date: _____ Result: _____

Remarks: _____

[Signature]
Signature of Examining Physician

M.D.

Date of Examination: 9-7-07

4467 Old Branch Ave
Address of Examining Physician

#105

Telephone No.: 301 899 0626
(Area Code)

Temple Hills, MD

Dr Rick Bryson



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

HEALTH CERTIFICATE FOR STAFF

Name: NANOSI, LARY OBI

Sex: ☒ Male ☐ Female

Date of Birth: 12/24/57

Telephone No.: (301) 326 8600

Address: 6100 RIGGS ROAD HYATTSVILLE, MD 20783

I have examined the above-named person and certify that he/she is:

- ☒ Free from disease in communicable form.
- ☒ As of this date, the person appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to other people.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ Tine ☒ PPD

Date: 06/20/07 Result: NEGATIVE

Chest X-Ray: Date: _____ Result: _____

Remarks: _____

Robert G. Greenfield, M.D.

Silver Spring Medical Center

ENGL./SPANISH BILL. CLINICS MED./DENT.

8121 GEORGIA AVE. THE WORLD BUILDING

SILVER SPRING, MD 20910

Address of Examining Physician

Date of Examination: 09/10/07

Telephone No.: SILVER SPRING MEDICAL CENTER
ENGL./SPANISH BILL. CLINICS MED./DENT.
(And Other) 8121 GEORGIA AVE. THE WORLD BUILDING
SILVER SPRING, MD 20910
(301) 587-8600

LeRoy Hall, M.D.
ADULT UROLOGY

SUITE 120
WASHINGTON HOSPITAL CENTER
PHYSICIAN'S OFFICE BUILDING
106 IRVING STREET, N.W.
WASHINGTON, D.C. 20010
TELEPHONE: (202) 722.0953

October 11, 2007

TO WHOM IT MAY CONCERN,

I have examined Dr. Richard A. Wilson, Jr., and found him to be free of communicable diseases. A PPD on 8/22/2007 was negative (zero induration).

If I can be of assistance in the future, please feel free to contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "Leroy Hall, M.D.", with a stylized flourish at the end.

Leroy Hall, M.D.

LANGLEY PARK WALK-IN MEDICAL CLINIC

Phone: (301)-445-7026

1040 E. University Blvd. * Silver Spring, MD * 20903



Date 01/20/07

Name OLIVER, MABEL O

D.O.B. 8/20/48

Address _____

Height 4'9"

Weight 179 LB

T 97.8°F P 100/mm B/P 150/92

This is to certify that OLIVER, MABEL O is in good health and free of communicable diseases.

Tuberculin Test

Type Heft x m

Date given 6/13/06

Date read 6/13/06

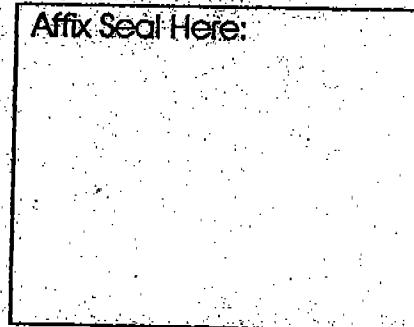
Result NEGATIVE

Date of Physical Examination 01/20/2007

BB. Tamm
M.D. Signature

Langley Park Walk-In Medical Clinic
1040 University Blvd., East
Silver Spring, Maryland 20903
Telephone 301-445-7026

Affix Seal Here:





GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

HEALTH CERTIFICATE FOR STAFF

Name: Mary Ann Lewis

Sex: ☐ Male ☒ Female

Date of Birth: 12-23-49

Telephone No.: 7351 3628

Address: 1854 Kendall St. NE, #104 DC, 20002

I have examined the above-named person and certify that he/she is:

1. ☒ Free from disease in communicable form.
2. ☒ As of this date, the person appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to other people.

In addition to a general physical health examination, the following tests have been done:

Tuberculosis test (Check One): ☒ Tine ☐ PPD

Date: 6-27-06 Result: neg

Chest X-Ray: Date: 12-27-05 Result: neg to pneumonia

Remarks: Mrs Lewis is capable of performing her duties as a counselor.

Dr. Richard W. Miller M.D.
Signature of Examining Physician

Date of Examination: 11-7-09

Woodbridge Health Clinic - 2146 24th St. NE
Address of Examining Physician

Telephone No.: 21281-1160
(Area Code)

Northside Medical Services Corporation Occupational Medical Examination
Physician's Worksheet
(202) 388-6000

Name: FAOSAT. A. ATORAJAIY DOB 2/16/52 Tel 240-491-6908 Date: SEPT/11/07
Address: 6306 23rd AVENUE City HYATTSVILLE State MD Zip 20782

Applicant: Have you had or been treated for any of the following: (Please check Yes or No to each question)

	Yes	No
Hypertension		<input checked="" type="checkbox"/>
Operations		<input checked="" type="checkbox"/>
Head Injury		<input checked="" type="checkbox"/>
Menstrual Problems		<input checked="" type="checkbox"/>
Mental Health Illness		<input checked="" type="checkbox"/>
Chronic Back Pain	<input checked="" type="checkbox"/>	
Tuberculosis		<input checked="" type="checkbox"/>
Stomach Problems		<input checked="" type="checkbox"/>

	Yes	No
Diabetes		<input checked="" type="checkbox"/>
Seizures		<input checked="" type="checkbox"/>
Skin Disease		<input checked="" type="checkbox"/>
Asthma		<input checked="" type="checkbox"/>
Sinus Trouble	<input checked="" type="checkbox"/>	
Hernia		<input checked="" type="checkbox"/>
Heart Disease		<input checked="" type="checkbox"/>
Other		

Explain all Yes responses _____

List ANY/ALL medication(s) you are presently taking: _____

I have read the above and declare that I have had no disease, illness or ailment other than as specifically noted above.

Signature of applicant _____

TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY

Chest X-Ray/ Mantoux / PPD Test Date 7-16-98 L/R Arm Results Neg Date 7-16-98
Neck Ne Mouth Ne Glasses: No Vision: R. 20/25 L. 20/25
Height 5'7" Weight 287 Urinalysis: Specific Gravity 1.025 Glucose Neg Alb. Neg
B/P 152/110 Pulse 82 Resp. 20 Temp. 98.6 Diabetic No Insulin dependent No
Heart Normal Lungs Clear Asthmatic No Abdomen Ne Tenderness No Hernia No
Skin Clear Eczema No Rash No
Reflexes Normal Genitalia Deferred Liver Ne Inguinal Ne
Prosthesis No Thyroid Not palpable
Menstrual History: (Normal) _____ (Abnormal) _____ Not Applicable ☒ Other: _____
Chest X-Ray _____ (results) _____ Drug testing _____ (results) _____

Abnormalities and/or other significant findings/recommendations (please explain in detail)

Obesity

In my professional judgment and by examination FAOSAT ATORAJAIY is/is not found to be physically qualified for employment.

Signature of Examining Physician _____

Date 09-11-07

NYSC 01/98/05 Form 1000
NORTHSIDE MEDICAL SERVICES CORPORATION
4121 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019
TEL (202) 388-6000
FAX (202) 388-6001



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

HEALTH CERTIFICATE FOR STAFF

Name: ALFONSO HANTHARDGE

Sex: ☒ Male ☐ Female

Date of Birth: 10/27/1951

Telephone No.: 240-2713625

Address: _____

I have examined the above-named person and certify that he/she is:

1. ☐ Free from disease in communicable form.
2. ☒ As of this date, the person appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to other people.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ Tine ☒ PPD

Date: 3-29-07 Result: φ Neg

Chest X-Ray: Date: _____ Result: _____

Remarks: Neg

Reino Smith M.D.
Signature of Examining Physician

Date of Examination: 03/27/07

CNC
Address of Examining Physician

Telephone No.: 301 459 9113
(Area Code)

4451 6 Barrett Pl
Laurel Md 20706

(301) 459-9113



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

HEALTH CERTIFICATE FOR STAFF

Name: Darline Peoples Moore Sex: ☐ Male ☒ Female
Date of Birth: 2-2-64 Telephone No.: 301-919-8000
Address: 6321 Langfellow St. Riverdale M.D. 20737

I have examined the above-named person and certify that he/she is:

1. ☒ Free from disease in communicable form.
2. ☒ As of this date, the person appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to other people.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ Tine ☒ PPD

Date: 8-22-07 Result: Negative

Chest X-Ray: Date: _____ Result: _____

Remarks: _____

JOLAN RHODES, M.D., M.D.
Signature of Examining Physician
3331 TOLEDO TERRACE, SUITE 207
HYATTSVILLE, MARYLAND 20782
Address of Examining Physician

Date of Examination: 8-22-07
Telephone No.: 301-559-6356
(Area Code)

84

American
Red Cross



Together, we can save a life

This recognizes that

NCHANG ANGWAFO CHANTAI
has completed the requirements for

CPR - ADULT

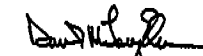
conducted by

Careco, Inc.

Date completed

04/20/2007

The American Red Cross recognizes this certificate
as valid for **1** year(s) from completion date.



Chairman, American Red Cross

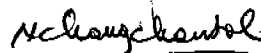
Instructor's Signature



Chapter

National Capital Area Chapter

Holder's Signature



AHA
Region

Maryland DC Region

Community
Training Center

PPM 1-800-788-2771

Training
Site

8722 McLain Avenue

202-409-3611

Instructor

Ivo Ngosong

Holder's
Signature

Acha

©2000 American Heart Association

Transporting with this card will alter its appearance.

70-2915

American Heart
Association



Learn and Live.

Healthcare Provider

Gerakline Acha

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the BLS for Healthcare Providers (CPR & AED) Program.

07/28/2007

Issue Date

07/2009

Recommended Renewal Date

COMPREHENSIVE CARE II, INC., PROGRAM DOCUMENTATION SHEET

Person Name: Maria Calabrese

Month/Year: _____

Goal: Improve Money Management

Start Date: 11/07

End Date: 01/08

Objective: Given verbal prompts, Ms. Callabrese will make a purchase from a store 80% of recorded trails per month for 3 consecutive months

Frequency: 2/Week

Program Days:

Wed/Sat

TASK

Maria will:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1. Enter the store																															
2. Walk to an isle																															
3 Choose an item																															
4. Take item to the cashier																															
5. Pay for item																															
6. Collect change and receipt																															
Staff Initials																															

LOA: Independence (I) = Absence of assistance Verbal (V) = Staff use speech ONLY Gestural (G) = Staff use speech and pointing
 Model/Demonstration (M) = staff use speech and ACTUAL DEMONSTRATION PHYSICAL (P) = Staff use speech and periodic touch throughout task
 Hand Over Hand (H) = staff use speech and maintain Physical Contact throughout task Refuse (R) – Refused to participate

Date	Comments	Date	Comments

QMRRP Monthly Review: _____ Date: _____

COMPREHENSIVE CARE II, INC., PROGRAM DOCUMENTATION SHEET

Person Name: Maria Calabrese

Month/Year: _____

Goal: To Enhance Community Survival Skills

Start Date: 11/07

End Date: 01/08

Objective: Given pictures of survival signs, Ms. Callabrese will independently identify community survival signs on 100% of trials for 3 consecutive months

Frequency: 3 Times per Week

Program Days:

Tuesdays, Wednesdays, & Saturdays

TASK

Ms. Calabrese will identify the under-mentioned signs when requested:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Stop																															
Yield																															
Walk																															
Exit																															
Don't Walk																															
Wait																															
Hospital																															
Staff Initials																															

LOA: Independence (I) = Absence of assistance Verbal (V) = Staff use speech ONLY Gestural (G) = Staff use speech and pointing

Model/Demonstration (M) = staff use speech and ACTUAL DEMONSTRATION PHYSICAL (P) = Staff use speech and periodic touch throughout task

Hand Over Hand (H) = staff use speech and maintain Physical Contact throughout task Refuse (R) – Refused to participate

Date	Comments	Date	Comments

QMRP Monthly Review: _____

Date: _____

QMIRP Monthly Review: _____

Date: _____